

Wisconsin Department of Regulation & Licensing

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PHARMACY EXAMINING BOARD

PHARMACIST CERTIFICATE OF PROFESSIONAL EDUCATION

THIS FORM MUST BE COMPLETED BY YOUR PHARMACY SCHOOL
AND RETURNED TO THE PHARMACY EXAMINING BOARD

APPLICANT - Please complete this section.

NAME (First, Middle, Maiden, Last)

Social Security Number*

____ - ____ - ____

ADDRESS (City, State, Zip)

Date of Graduation

____ / ____ / ____

CERTIFYING SCHOOL - Please complete this section.

NAME OF INSTITUTION

LOCATION OF INSTITUTION

DEGREE AWARDED

MAJOR

Was this a 5 or 6 year program? ____ Yes ____ No
If not, list number of years. _____

DATE DIPLOMA GRANTED**

Signature of Dean/Department Head/Registrar

Date

SCHOOL SEAL

* For use in the school locating your records.

**** DO NOT COMPLETE THIS FORM UNTIL THE INDIVIDUAL NAMED ABOVE HAS ACTUALLY GRADUATED.** Anticipated dates of graduation will not be accepted.

#2512 (Rev. 2/03)

Ch. 447, Stats.

Committed to Equal Opportunity in Employment and Licensing